



## Enrollment Assessment Acute

► **Enrollment Date:**      /      /  
   mm   dd   yyyy

► **ESM Client ID:**

► **Provider ID:**

**Questions (Q) marked with ► must be completed.**

**Boxes marked with ★ = Refer to Key at end of form**

**First Name:**

**Middle Initial:**

**Last Name:**

**Suffix:**

► **1. Client Code:**     

► **2. Intake/Clinician Initials:**     

► **3. Do you own or rent a house, apartment, or room?**    ☐ Yes    ☐ No    *If the answer to Q. 3 is Yes, skip to Q. 3b, if 'No', answer Q. 3a.*

**3a. Are you Chronically Homeless?**  
(HUD Definition in Manual)      ☐ Yes    ☐ No

► **3b. ZIP Code of Last Permanent Address:**  
*Do **Not** put zip code of Program. See Manual for definition of Permanent.*

► **3c. Where did you stay last night?**

- |  |  |  |
|--|--|--|
| 1 <input type="checkbox"/> Emergency shelter                             | 7 <input type="checkbox"/> Jail, prison or juvenile detention facility   | 13 <input type="checkbox"/> Foster care home or foster care group home |
| 2 <input type="checkbox"/> Transitional housing for homeless persons     | 8 <input type="checkbox"/> Room, apartment, or house that you own or rent  | 14 <input type="checkbox"/> Place not meant for habitation             |
| 3 <input type="checkbox"/> Permanent housing for formerly homeless       | 9 <input type="checkbox"/> Staying or living with a family member  | 15 <input type="checkbox"/> Other Specify _____                        |
| 4 <input type="checkbox"/> Psychiatric hospital or other psych. Facility | 10 <input type="checkbox"/> Staying or living with a friend  | 88 <input type="checkbox"/> Refused                                    |
| 5 <input type="checkbox"/> Substance abuse treatment facility or detox   | 11 <input type="checkbox"/> <b>Room, apartment, or house to which you cannot return</b> (future return can be uncertain) |  |
| 6 <input type="checkbox"/> Hospital (non-psychiatric)                    | 12 <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher                                    |  |

► **4. Do you consider yourself to be transgender?**      ☐ Yes    ☐ No    ☐ Refused

**4a. If you answered Yes to Q. 4, please specify:**      ☐ Male to Female    ☐ Female to Male    ☐ Other, specify \_\_\_\_\_

► **5. Do you consider yourself to be:**    ☐ Heterosexual    ☐ Gay/Lesbian    ☐ Bisexual    ☐ Other, specify \_\_\_\_\_    ☐ Refused

► **6. Number of days between initial contact with the program by the client or someone on behalf of the client and enrollment:** (unknown = 999)            *See Manual to help determine wait time.*

► **7. Source of Referral:**      ★

► **8. Frequency of attendance at self-help programs (e.g. AA, NA) in 30 days prior to Enrollment:**        ★

**9. Additional Client Type** (Check **ALL** that apply)

*New* ☐ Student      ☐ Postpartum      ☐ Methadone      *New* ☐ Injectable Naltrexone    ☐ Parole      ☐ Federal Parole  
(e.g. Vivitrol)

☐ Pregnant    *Change* ☐ Veteran/ Any    *Change* ☐ Buprenorphine      ☐ Probation      ☐ Federal Probation  
Military Service      (e.g. Suboxone)

► **10. Do you have children?**    ☐ Yes    ☐ No    ☐ Refused      *If answer to Q. 10 is 'Yes', complete Qs 10a-10d. If no, skip to Q. 11*

**10a. Number Children Under 6:**            **10b. Number of Children 6-18:**            **10c. Children Over 18:**     

**10d. Are any of the children of the Native American race? (i.e., American Indian)**      1 ☐ Yes    2 ☐ No

► **11. Are you the primary caregiver for any children?** *If yes, see manual. If the client is the primary caregiver of children you must assess as to the children's welfare and what arrangements have been made for their care in your full clinical assessment!!!*      ☐ Yes    ☐ No    ☐ Refused

► **12. Employment status at Enrollment:**       ★      ► **13. Number of days worked in the past 30 days:**     

► **14. Where do you usually live? (Where has the client spent/slept most of the time over the last 12 months?)**

- |   |   |  |  |
|---|---|--|--|
| 1 <input type="checkbox"/> House or apartment           | 3 <input type="checkbox"/> Institution          | 5 <input type="checkbox"/> Shelter/mission | 7 <input type="checkbox"/> Foster Care |
| 2 <input type="checkbox"/> Room/boarding or sober house | 4 <input type="checkbox"/> Group home/treatment | 6 <input type="checkbox"/> On the streets  | 88 <input type="checkbox"/> Refused    |

<b>► 15. Who do you live with? (Check all that apply)</b> <input type="checkbox"/> Alone <input type="checkbox"/> Child 6-18 <input type="checkbox"/> Spouse/Equivalent <input type="checkbox"/> Other Relative <input type="checkbox"/> Child under 6 <input type="checkbox"/> Child over 18 <input type="checkbox"/> Parents <input type="checkbox"/> Roommate/Friend							
<b>► 16. Use of Mobility Aid: (Check all that apply)</b> <input type="checkbox"/> None <input type="checkbox"/> Crutches <input type="checkbox"/> Walker <input type="checkbox"/> Manual Wheelchair <input type="checkbox"/> Electric Wheelchair							
<b>► 17. Vision Impairment</b> <input type="checkbox"/> ★		<b>► 18. Hearing Impairment</b> <input type="checkbox"/> ★		<b>► 19. SelfCare/ADL Impairment</b> <input type="checkbox"/> ★		<b>► 20. Developmental Disability</b> <input type="checkbox"/> ★	
<b>► 21. Prior Mental Health Treatment:</b> 0 <input type="checkbox"/> No history      1 <input type="checkbox"/> Counseling      2 <input type="checkbox"/> One hospitalization      3 <input type="checkbox"/> More than one hospitalization							
<b>► 22. During the past 12 months, did you take any prescription medication that was prescribed for you to treat a mental or emotional condition?</b> 1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No      88 <input type="checkbox"/> Refused      99 <input type="checkbox"/> Unknown							
<b>► 23. Number of prior admissions to each substance abuse treatment modality (0 - 5 admissions, '5' = 5 or more, 99=unknown) Do not count this tx. episode.</b> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"><input type="text"/> Detox</div> <div style="width: 50%;"><input type="text"/> Outpatient</div> <div style="width: 50%;"><input type="text"/> Drunk Driver</div> <div style="width: 50%;"><input type="text"/> Other</div> <div style="width: 50%;"><input type="text"/> Residential</div> <div style="width: 50%;"><input type="text"/> Opioid</div> <div style="width: 50%;"><input type="text"/> Section 35</div> </div>							
<b>► 24. Currently receiving services from a state agency: (Check all that apply)</b> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"><input type="checkbox"/> None</div> <div style="width: 50%;"><input type="checkbox"/> DMH does client have a case mgr.?</div> <div style="width: 50%;"><input type="checkbox"/> DTA e.g. food stamps</div> <div style="width: 50%;"><input type="checkbox"/> MCDHH Deaf</div> <div style="width: 50%;"><input type="checkbox"/> DCF was DSS</div> <div style="width: 50%;"><input type="checkbox"/> DDS was DMR</div> <div style="width: 50%;"><input type="checkbox"/> MRC Mass Rehab</div> <div style="width: 50%;"><input type="checkbox"/> Other</div> <div style="width: 50%;"><input type="checkbox"/> DYS youth services</div> <div style="width: 50%;"><input type="checkbox"/> DPH e.g. HIV/STD; not BSAS tx..</div> <div style="width: 50%;"><input type="checkbox"/> MCB Commission for Blind</div> </div> <p style="color: red; font-size: small;">See manual for auto generated associations (e.g. Client Type Probation – OCP services.)</p>							
<b>► 25. Number of arrests in the past 30 days:</b> <input type="text"/> (Section 35 is not an arrest, it is a civil commitment)							
<b>► 26. History Substance Mis-use, Nicotine/Tobacco Use &amp; Gambling</b> <small>For pharmaceutical drugs prescribed for the client, only code misuse (more than the recommended dosage) or non-medical use. (Example - If the client was prescribed a benzodiazepine for a mental health disorder and used per instruction, do not list on History Table.) Note: For the safety of the client all drugs used must be recorded in the client record. (See Manual for commercial names.)</small>						<div style="display: flex; flex-direction: column; align-items: center;"> <div style="display: flex; justify-content: space-between; width: 100%;"> <span>Have You Ever Mis-Used/Bet</span> </div> <div style="display: flex; justify-content: space-between; width: 100%;"> <span>Y</span> <span>N</span> </div> </div>	
A	Alcohol <i>For Alcohol, enter first age of intoxication</i>						
B	Cocaine						
C	Crack						
D	Marijuana / Hashish						
E	Heroin						
F	Prescribed Opiates <i>Misuse/non-medical use of pharmaceutical opiates which were prescribed for the client.</i>						
G	Non-prescribed Opiates <i>Non-medical use of pharmaceutical opiates which were not prescribed for the client</i>						
H	PCP						
I	Other Hallucinogens						
J	Methamphetamine						
K	Other Amphetamines						
L	Other Stimulants						
M	Benzodiazepines						
N	Other Tranquillizers						
O	Barbiturates						
P	Other Sedatives / Hypnotics						
Q	Inhalants						
R	Over the Counter						
S	Club Drugs						
U	Other						
X	Nicotine/Tobacco <i>Includes cigarettes, cigars, chewing tobacco, inhalers</i>						
Y	Gambling <i>Includes any of the types listed in Q 28a (see next page)</i>						N/A

<b>27. Number of cigarettes currently smoked per day. (Indicate number of cigarettes, not number of packs: 1 pack = 20 cigarettes)</b> <b>If client uses another type of nicotine/tobacco product, mark Zero (0).</b> <i>If client does not have a history of nicotine/tobacco use, Q. 27 and go to Q. 28a</i>			<div style="border: 1px solid black; height: 20px; width: 40px; margin: 0 auto;"></div>
<b>28a. Types of last regular gambling: (check all that apply)</b> <i>If person does not have a gambling history, skip Qs. 28a &amp; b and go to Q. 29</i>			
<input type="checkbox"/> Lottery - Scratch Tickets	<input type="checkbox"/> Slot Machines	<input type="checkbox"/> Sports Betting	<input type="checkbox"/> Stock Market
<input type="checkbox"/> Lottery - Keno	<input type="checkbox"/> Casino Games	<input type="checkbox"/> Bingo	<input type="checkbox"/> Internet Gambling
<input type="checkbox"/> Lottery/Numbers Games	<input type="checkbox"/> Card Games	<input type="checkbox"/> Dog/Horse Tracks, Jai Alai	
<b>28b. Have you ever thought you might have a gambling problem, or been told you might?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused			
<b><i>Nicotine/Tobacco and Gambling CANNOT be marked as a primary/secondary/or tertiary drug. This applies for Substances A through U Only.</i></b> <b><i>IT IS VITAL THAT PATIENTS BE ASKED IF THEY HAVE a SECONDARY and/or TERTIARY DRUG OF CHOICE. Clinicians may rank substances based on their clinical opinion after review of the substance use history and not necessarily client report.</i></b>			
<b>▶ 29. Rank substances by entering corresponding letter for substances listed above in Question 26. (If no secondary or tertiary substance, leave blank)</b>			
Primary Substance <div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div>	Secondary Substance <div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div>	Tertiary Substance <div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div>	
<b>▶ 30. Needle Use?</b>			
0 <input type="checkbox"/> Never    1 <input type="checkbox"/> 12 or more months ago    2 <input type="checkbox"/> 3 to 11 months ago    3 <input type="checkbox"/> 1 to 2 months ago    4 <input type="checkbox"/> Past 30 days    5 <input type="checkbox"/> Last week			
<b>▶ 31a. How many overdoses have you had in your lifetime?</b> <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div>		<b>▶ 31b. How many overdoses have you had in past year?</b> <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div>	

Q7. Source of Referral at Enrollment					
Code		Code		Code	
01	Self, Family, Non-medical Professional	20	<i>Change</i> Health Care Professional, Hospital		67 <i>Discontinued</i>
02	BMC Central Intake/Room 5	21	Emergency Room	68	Office of the Commissioner of Probation
03	ATS/Detox	22	HIV/AIDS Programs	69	Massachusetts Parole Board
04	Transitional Support Services/TSS	23	Needle Exchange Programs	70	Dept. of Youth Services
05	Clinical Stabilization Services/CSS-CMID	26	<i>New</i> Mental Health Professional	71	Dept. of Children and Families
06	Residential Treatment		27 through 29 <i>Discontinued</i>	72	Dept. of Mental Health
07	Outpatient SA Counseling	30	School Personnel, School System/Colleges	73	Dept. of Developmental Services
08	Opioid Treatment	31	<i>New</i> Recovery High School		74 through 76 <i>Discontinued</i>
09	Drunk Driving Program		32 through 39 <i>Discontinued</i>	77	Mass. Rehab. Commission
10	Acupuncture	40	Supervisor/Employee Counselor	78	Mass. Commission for the Blind
11	Gambling Program		41 through 49 <i>Discontinued</i>	79	Mass. Comm. For Deaf & Hard of Hearing
	12 & 13 <i>Discontinued</i>	50	Shelter	80	Other State Agency
14	Sober House	51	Community or Religious Organization		
15	Information and Referral		52 through 58 <i>Discontinued</i>	99	Unknown
16	<i>New</i> Recovery Support Centers	59	Drug Court		
17	Second Offender Aftercare	60	Court - Section 35		
18	Family Intervention Program		61 & 62 <i>Discontinued</i>		
19	Other Substance Abuse Treatment	63	Court - Other		
		64	Prerelease, Legal Aid, Police		
			65 <i>Discontinued</i>		
		66	Office of Community Corrections		

Q 8 Frequency of Attendance at Self-Help Programs			
Code		Code	
01	No attendance in the past month	05	16-30 times in past month (4 or more times per week)
02	1-3 times in past month (less than once per week)	06	Some attendance, but frequency unknown
03	4-7 times in past month (about once per week)	99	Unknown
04	8-15 times in past month (2 or 3 times per week)		

Q 12 Employment Status at Enrollment					
Code		Code		Code	
1	Working Full Time	6	Not in Labor Force - Retired	11	Volunteer
2	Working Part time	7	Not in Labor Force - Disabled	12	Other
3	Unemployed - looking	8	Not in labor force - Homemaker	13	Maternity/Family Leave
4	Unemployed - Not Looking	9	Not in labor force - Other	99	Unknown
5	Not in labor force - Student	10	Not in labor force - Incarcerated		

Code	Q. 17 Vision Impairment
0	None: Normal Vision
1	Slight: vision can be or is corrected with glasses/lenses
2	Moderate: "Legally blind" but having some minimal vision
3	Severe: No usable vision

Code	Q. 18 Hearing Impairment
0	None: Normal hearing requiring no correction
1	Slight: Hearing is or can be adequately corrected with amplification (eg hearing aid)
2	Moderate: Hard of hearing, even with amplification
3	Severe: Profound deafness

Code	Q 19 Self Care/ADL Impairment
0	None: No problem accomplishing ADL skills such as bathing, dressing and other self-care
1	Slight: Uses adaptive device(s) and/or takes additional time to accomplish ADL but does not require attendant
2	Moderate: Needs personal attendant up to 20 hours a week for ADL
3	Severe: Requires personal attendant for over 20 hours a week for ADL

Code	Q. 20 Developmental Disability
0	None
1	Slight Developmental Disability
2	Moderate Developmental Disability
3	Severe Developmental Disability

Code	Last Use Substances
1	12 or more months ago
2	3-11 months ago
3	1-2 months ago
4	Past 30 days
5	Used in last week

Q 26: SUBSTANCE MIS-USE / NICOTINE/TOBACCO / GAMBLING HISTORY

Code	Frequency of Last Use
1	Less than once a month
2	1-3 times a month
3	1-2 times a week
4	3-6 times a week
5	Daily
99	Unknown

Code	Route of Administration
1	Oral (swallow and/or chewing)
2	Smoking
3	Inhalation
4	Injection
5	Other